Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

URGENT SURGERY ASSOCIATES
2710 SWISS AVE
DALLAS TX 75204

Respondent Name
CITY OF GARLAND

Carrier's Austin Representative Box
Box Number 11

MFDR Tracking Number
M4-13-1905-01

MFDR Date Received
MARCH 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The information obtained from the hospital at, or shortly after, the time of service indicated Medicare as the primary payer and Blue Cross as the secondary payer. We submitted our claim for dates of service 8/28/13-8/31/13 to, and were paid by, Medicare and Blue Cross. We received a letter from Texas Political Subdivisions on 11/15/12, along with a copy of the patient's statement (presumably sent to the carrier by the patient) indicating we should submit our bill(s) to them on a HCFA 1500. We submitted 4 charges, one of which (dos 8/28/12) was paid on initial submission, one which (dos 8/30/12) was paid on appeal, and two more (dos 8/29/12 & 8/31/12) of which remain denied on appeal."

Amount in Dispute: $460.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
.August 29, 2012 August 31, 2012	CPT Code 99233 CPT Code 99238	$460.00	$275.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a

health care provider.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 148 – This procedure on this date was previously reviewed.
   - 18 – Duplicate claim/service.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Texas Labor Code Section 408.0272(c) states, "Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim. Review of the documentation submitted by the requestor finds that the respondent contacted the requestor on November 15, 2012. At that time the requestor submitted to the respondent a bill. The respondent returned the documentation and asked that the requestor resubmit the bill on form HCFA 1500 or UB 92. The requestor submitted the HCFA 1500's and according to the Explanation of Review was received by the carrier on December 13, 2012. Therefore the requestor has not forfeited the right to reimbursement.
2. Documentation submitted by the requestor supports reimbursement as follows:
   - CPT Code 99233 – (54.86 ÷ 34.0376) x $100.48 x 1 unit = $161.95
   - CPT Code 99238 – (54.86 ÷ 34.0376) x $70.18 x 1 unit = $113.11

   Total reimbursement due: $161.95 + 113.11 = $275.06

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $275.06

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $275.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 10, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.